

# STANDARD CERTIFICATE OF DEATH

State File No. 30723  
4057

BIRTH NO. _____		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY JACKSON			
b. CITY (If outside corporate limits, write RURAL and give township) KANSAS CITY 1		c. LENGTH OF STAY (In this place) 9 YRS		c. CITY (If outside corporate limits, write RURAL and give township) KANSAS CITY		3118	
d. FULL NAME OF HOSPITAL OR INSTITUTION 910 E 11th ST. Apt. 5				d. STREET ADDRESS (If rural, give location) 910 E 11th ST. Apt. 5			
3. NAME OF DECEASED (Type or Print) LELAND		a. (First)		b. (Middle) WILLIAMS		c. (Last)	
5. SEX MALE		6. COLOR OR RACE WH.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH MARCH 13-1903	
9. AGE (In years last birthday) 47		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY UNEMPLOYED		11. BIRTHPLACE (State or foreign country) KIRKVILLE, Mo	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME James Williams		13b. MOTHER'S MAIDEN NAME Ruth Hoff		14. NAME OF HUSBAND OR WIFE ETTA WILLIAMS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. DO NOT KNOW		17. INFORMANT'S SIGNATURE OR NAME ETTA WILLIAMS		ADDRESS 910 E 11th ST.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobal Pneumonia				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES							
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.							
DUE TO (b) Acute Gastritis							
DUE TO (c) Chronic Cholelithiasis							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.				Circulation of Liver			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE Geo. C. Kealhofer (Degree or title)				23b. ADDRESS 3447 Pearl St. St. Louis		23c. DATE SIGNED 9-25-50	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 5 Sept 25-50		24c. NAME OF CEMETERY OR CREMATORY Hennes Cemetery		24d. LOCATION (City, town, or county) (State) Oskaloosa Iowa	
DATE REC'D BY LOCAL REG. 9-25-50		REGISTRAR'S SIGNATURE Geraldine Holmes		FUNERAL DIRECTOR'S SIGNATURE Passavant Bros		ADDRESS ICCMO	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed.....

*Leonard E. Parmenter*

Signed.....

Student Embalmer

Licensed Embalmer No. *4554*

P. O. Address *16 Cmo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.